Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name: ________________________________ Today's date: ______________

Social Security No: _____________ Date of Birth: _________ Age: ____ Sex: ______

Driver's license No.: _________________ State :________

Home address: ____

Phone: _____________ Cell phone: ___________________Email________________________

Billing address *(if different from above):* _______________________________________

Employer/occupation: _________________________ Business phone: ______________

Spouse's name: _________________________ Spouse's phone : __________________

Emergency phone *(other than spouse) :*___________________________________

Primary dental insurance Group No.: ____________________________

Secondary dental insurance Group No.: ___________________________

Subscriber's name: ____

Subscriber's Social Security No: ________________

Name of your medical doctor : _____________________________________

Date of last visit to medical doctor : ______________________________

Name of previous dentist : _____________________________________

Date of last visit to dentist: ____

Referred to us by : ____

Sandia Heights
DENTAL CARE

DENTAL HISTORY

Please check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning ______ /______
- Your last oral cancer screening ______ /______
- Your last complete X-Rays ______ /______

Name of Previous Dentist ____________________

City ____________________ State ____________

Phone Number ____________________

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_______ For how long? _______		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? ____________________

What is the most important thing to you about your future smile and dental health? ____________________

What is the most important thing to you about your dental visit today? ____________________

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other ____________		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	____________		
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐	____________		
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐	____________		
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO	
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐	Other ____________
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐	____________
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	____________

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for? ____________________

What medications are you currently taking? ____________________

Family Physician ____________ Phone Number ____________

Consent:
The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

____________________ ____________ ____________________
Patient Signature (Parent if child) **Date** **Dentist Signature**

PERMISSION TO SHARE MEDICAL/DENTAL INFORMATION

This addendum to the Sandia Heights Dental Care Privacy Policy is used to detail the specific people that we may share your personal medical information with. All of the guidelines and policies detailed in the signed Privacy Policy, regarding the safeguarding of your information, will be observed in all cases. This list will contain the ONLY people with whom we will share your information with the exception of the professionals detailed on our Privacy Policy.

INFORMED CONSENT

I understand that my medical and dental records are closely protected under federal law, and I give Sandia Heights Dental Care, Dr. Monique Lee, and her associates permission to obtain or share my medical information with the following:

Name/Relationship:

1. ____
2. ____
3. ____

Signature of patient/guardian _______________________________ Date___________________